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RISKY PREGNANCY: LIABILITY, BLAME, AND INSURANCE IN THE GOVERNANCE OF PRENATAL HARM

ROXANNE MYKITIUK[†] & DAYNA NADINE SCOTT[‡]

I. INTRODUCTION

Feminist theory has exposed the body of the pregnant woman as one that is continuously made into the object of analysis and regulation,¹ and feminist scholars have sought to understand the evolving contestation over the boundary between the woman and the fetus: the life sometimes conceptualized as part of her and other times as carried with her.² Together, they are “not-one-but-not-two.”³ “Always marked by race, class and ability,” as Johnson notes, “the pregnant body is sometimes celebrated, sometimes reviled,”⁴ and, as we will argue, always judged.

As historian Barbara Duden has shown, the state of “expecting a baby” has been transformed in recent years from one of “being in good hope”⁵ to

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¹ See Rebecca Johnson, “Blurred Boundaries: A Double-Voiced Dialogue on Regulatory Regimes and Embodied Space” (2005) 9 *Law Text Culture* 157 at 157.

² See *ibid* at 157–58; Adrienne Cecile Rich, *Of Woman Born: Motherhood as Experience and Institution* (New York: Norton, 1976); Jenny Morgan, “Foetal Imaginings: Searching for a Vocabulary in the Law and Politics of Reproduction” (2000) 12 *CJWL* 371.

³ Isabel Karpin, “Legislating the Female Body: Reproductive Technology and the Reconstructed Woman” (1992) 3 *Colum J Gender & L* 325 at 329.

⁴ Johnson, *supra* note 1 at 158.

⁵ Silja Samerski, “The ‘Decision-Trap’: How Genetic Counseling Transforms Pregnant Women into Managers of Foetal Risk Profiles” in Kelly Hannah-Moffat & Pat O’Malley, eds, *Gendered Risks* (New York: Routledge-Cavendish, 2007) 55 at 59.

one of being in a state of bad expectation.⁶ Pregnancy is increasingly conceptualized as a risky state⁷ and the pregnant body is exposed as a site of risk governance and management wherein the principle aim is to protect the health of the developing fetus and to protect it from harm. Risk governance and management strategies aimed at protecting the fetus are carried out through a number of practices (e.g. surveillance and discipline) and a number of discourses (including medical, cultural, and legal) which we document and analyze throughout this article.

This article has four parts. In Part II, we situate techniques of risk governance within the current governmentality literature and examine them as part of a neo-liberal political project that has the effect of “individualizing” risk. In Part III, we explore how contemporary medical, public health, and popular-cultural discourses operate as techniques of risk governance “through which individuals are brought to work on themselves,”⁸ and demonstrate how these are extremely successful at accomplishing the translation between risk and blame in the context of pregnancy. In Part IV, we examine situations where pregnant women have refused to govern themselves in expected ways, in line with protecting the health of the fetus. In this context, we examine the current legal regime in Canada through which maternal responsibility for fetal exposure to the risk of harm and maternal liability for harm to the fetus and child once born, resulting from “risky” behaviours in pregnancy, are established and assessed. As we demonstrate, the most recent Canadian jurisprudence of the highest-level courts appears as a site of resistance in the trend towards translation from risk to blame in the context of the governance of maternal behaviour during pregnancy.

Finally, in Part V, we consider Alberta’s *Maternal Tort Liability Act*,⁹ which provides an exception to the common law by granting a civil cause of action to a child who sustains prenatal injuries as a result of the negligent use

⁶ Barbara Duden, *Disembodying Women: Perspectives on Pregnancy and the Unborn* (Cambridge, Mass: Harvard University Press, 1993).

⁷ See generally Lorna Weir, *Pregnancy, Risk and Biopolitics: On the Threshold of the Living Subject* (Oxford: Routledge, 2006) [Weir (2006)].

⁸ Paul Rabinow & Nikolas Rose, “Biopower Today” (2006) 1 *BioSocieties* 195 at 197.

⁹ SA 2005, c M-7.5 [MTLA].

or operation of a motor vehicle by the child's mother during her pregnancy (but limits that liability to circumstances in which the child's mother has motor vehicle insurance). Here, and in the final section, we explore the connections between liability and insurance raised by the Alberta example, and the extent to which they challenge the conclusion that linking risk with blame is necessarily an individualizing move. In the end, however, we note that liability inevitably comes with blame.

We attempt in this article to take up a scholarly task articulated by Hannah-Moffat and O'Malley: to pay attention to the processes through which risk governance techniques "create gendered subjectivities and to how risk regimes produce inequalities, undermine gains and reconfigure social and individual problems."¹⁰ In addition, this case study invites a further consideration of the role of law in neo-liberal governance, especially in light of the widespread refusal by courts to interpret and apply common law doctrines that would assign blame for harm where women have undertaken allegedly risky behaviours during pregnancy, and in light of the legislative development in Alberta in circumstances involving motor vehicle insurance.

II. CONSTRUCTIONS OF RISK AND RISK-BASED GOVERNANCE

There is a growing body of scholarship that treats "risk" as a *technique* of law and governance.¹¹ Governing with risk is seen as a means of channelling institutional practices and systems into a pattern that begins with *assessment* and

¹⁰ Kelly Hannah-Moffat & Pat O'Malley, "Gendered Risks: An Introduction" in Hannah-Moffat & O'Malley, *supra* note 5, 1 at 25.

¹¹ See e.g. Pat O'Malley, "The Government of Risks" in Austin Sarat, ed, *The Blackwell Companion to Law and Society* (Oxford: Blackwell, 2004) 292; Nikolas Rose, "Governing 'Advanced' Liberal Democracies" in Andrew Barry, Thomas Osborne & Nikolas S Rose, eds, *Foucault and Political Reason: Liberalism, Neo-Liberalism and Rationalities of Government* (London: UCL Press, 1996) 37; Jessica Polzer & Ann Robertson, "From Familial Disease to 'Genetic Risk': Harnessing Women's Labour in the (Co)Production of Scientific Knowledge about Breast Cancer" in Hannah-Moffat & O'Malley, *supra* note 5, 31.

moves through *prediction to management*.¹² The effect is argued to transform the pervasive uncertainties and indeterminacies generated by the interaction of complex social and biological systems into calculable probabilities of harm subject to management. The technique of risk governance is often viewed as a mechanism for making people more individually accountable for risk,¹³ and concomitantly, the technique is often tied directly to a neo-liberal political project.¹⁴

Socio-legal scholars have noted in recent years an increasing tendency of actors to both conceive of and address problems in the language of risk.¹⁵ At the same time, they acknowledge a “change in the way risk is articulated and deployed.”¹⁶ However, many of these socio-legal scholars working in a mode of “governmentality”¹⁷ reject the premise that risk-based government is a *new*

¹² Nikolas Rose, “Governing Risky Individuals: The Role of Psychiatry in New Regimes of Control” (1998) 5 *Psychiatry, Psychology & Law* 177.

¹³ Tom Baker & Jonathan Simon, eds, *Embracing Risk: The Changing Culture of Insurance and Responsibility* (Chicago: University of Chicago Press, 2002) at 178.

¹⁴ See e.g. O’Malley, *supra* note 11; Roxanne Mykitiuk, “Public Bodies, Private Parts: Genetics in a Post-Keynesian Era” in Brenda Cossman & Judy Fudge, eds, *Privatization, Law and the Challenge to Feminism* (Toronto: University of Toronto Press, 2002) 311; Mary Condon, “Gendered Risks of Retirement: The Legal Governance of Defined Contribution Pensions in Canada” in Hannah-Moffat & O’Malley, *supra* note 5, 145; Deborah Lupton, *Risk* (New York: Routledge, 1999); Deborah Lupton, “Introduction: Risk and Sociocultural Theory” in Deborah Lupton, ed, *Risk and Sociocultural Theory: New Directions and Perspectives* (Cambridge: Cambridge University Press, 1999) 1; Richard V Ericson & Kevin D Haggerty, *Policing the Risk in Society* (New York: Oxford University Press, 1997). The neo-liberal political project is a widespread, international political project aimed at restoring the power of economic elites. Generally, it has been tied to reforms seeking the protection of private property rights, and the promotion of free markets and free trade, and attempts at deregulating business and privatizing government assets and services. See generally David Harvey, *A Brief History of Neoliberalism* (New York: Oxford University Press, 2005).

¹⁵ O’Malley, *supra* note 11.

¹⁶ Baker & Simon, *supra* note 13 at 20.

¹⁷ Foucault coined the term “governmentality” to refer to the techniques and justifications through which “government”—in the sense of the whole array of programs, practices, policies and procedures by which both state and non-state actors seek to control the con-

technique and that risk consciousness is universally growing in response to scientific and technological advances. Instead, they argue that “risk is a *variable* technique of government”, and that we, in recent history, are witnessing the replacement of the “social” or “collective” forms of risk governance that dominated in the welfare era with “individualizing” forms.¹⁸ What is new about contemporary risk governance techniques is “the sense that ordinary people should exhibit some sort of responsibility for, and even expertise in managing, risk.”¹⁹

According to the governmentality school, current forms of risk governance tend to create “an obligation to act in the present in relation to the potential futures that now come into view.”²⁰ As Nikolas Rose explains,

By recognizing the impossibility of certainty about the future, [risk thinking] simultaneously makes this lack of certainty quantifiable in terms of probability. And once it has quantified the probability of a future event's occurring, decisions can be made and justified about what to do in the present²¹

The notion of “the future” as something amenable to alteration informs the conception of risk as a means of calculating and managing the uncertainties of the future.²² It is “a switch from a reactive to an active orientation toward uncertainty.”²³

duct of individuals and organizations—is effectuated. See Michel Foucault, “Governmentality” in Graham Burchell, Colin Gordon & Peter Miller, eds, *The Foucault Effect* (Chicago: University of Chicago Press, 1991) 87 at 103.

¹⁸ O'Malley, *supra* note 11 at 301.

¹⁹ Hannah-Moffat & O'Malley, *supra* note 10 at 2.

²⁰ Carlos Novas & Nikolas Rose, “Genetic Risk and the Birth of the Somatic Individual” (2000) 29 *Economy & Society* 485 at 486.

²¹ Nikolas Rose, “At Risk of Madness” in Baker & Simon, *supra* note 13, 209 at 214.

²² Gerda Reith, “Uncertain Times: The Notion of ‘Risk’ and the Development of Modernity” (2004) 13 *Time & Society* 383 at 384. As Mary Douglas states, “risk analysis is concerned with trying to turn uncertainties into probabilities.” *Risk Acceptability According to the Social Sciences* (Russell Sage Foundation, 1985) at 42.

²³ Thomas Lemke, “Disposition and Determinism—Genetic Diagnostics in Risk Society” (2004) 52 *Sociological Review* 550 at 552.

This focus on calculation means that risk governance is often portrayed as “amoral.”²⁴ Risks are held up as simple “realities,” and any behaviour that denies, ignores, or resists them can be safely dismissed as “irrational.”²⁵ However, “while the discourses and practices of risk-based government” are claimed to be “technical and thus neutral,” others contend they must be treated as “thoroughly imbued with politics.”²⁶ At the same time, those politics are not always obvious.²⁷ There is a heterogeneity to risk-based techniques:²⁸ “they can operate differently in different contexts.”²⁹

Contemporary risk-based governance also tends to focus on individual “empowerment”—the “attitudinal and knowledgeable reformation of individuals” through risk communication techniques so that individuals may make “informed decisions” about risk.³⁰ Consistent with a core idea of governing in contemporary liberal-democratic states that individuals should be free to control themselves and govern their own lives, the governance of individual subjects aims to promote processes of self-regulation and create the circumstances under which people may effectively govern themselves.³¹ “When law aligns with liberal governance,” as Weir notes, “it secures citizens as autonomous subjects with civil rights and freedoms guaranteed by the de-

²⁴ O'Malley, *supra* note 11 at 294.

²⁵ *Ibid.*

²⁶ Dayna Nadine Scott, “Risk as a Technique of Governance in an Era of Biotechnological Innovation” in Law Commission of Canada, ed, *Risk and Trust: Including or Excluding Citizens?* (Black Point: Fernwood, 2007) 23 at 26 [Scott (2007)]. Cf. Mariana Valverde, Ron Levi & Dawn Moore, “Legal Knowledges of Risk” in Law Commission of Canada, ed, *Law and Risk* (Vancouver: UBC Press, 2005) 86.

²⁷ See Scott (2007), *supra* note 26 at 26.

²⁸ Lorna Weir, “Recent Developments in the Governance of Pregnancy” (1996) 25 *Economy & Society* 372 at 379 [Weir (1996)].

²⁹ Scott (2007), *supra* note 26 at 26.

³⁰ O'Malley, *supra* note 11 at 302. See also Kevin Haggerty, “From Risk to Precaution: The Rationalities of Personal Crime Prevention” in Richard V Ericson & Aaron Doyle, eds, *Risk and Morality* (Toronto: University of Toronto Press, 2003) 193.

³¹ Mykitiuk, *supra* note 14 at 312.

mocratic sovereign.”³² This autonomous, self-regulating subject exercises his or her choices informed by expert knowledge, voluntarily seeking to maximize its opportunities and minimize its risks, allowing the state, optimally, to govern from a distance.

It is easy to see how this change is thought to introduce “new moralities of responsibility and accountability at multiple levels of society.”³³ Most important for this article is Mary Douglas’ demonstration of the way in which the apparently “neutral” risk discourse carries undercurrents of blame and responsibility.³⁴ In Douglas’ cultural approach to risk, “[w]hatever objective dangers may exist in the world, social organizations will emphasize those that reinforce the moral, political or religious order that holds the group together.”³⁵ Thus even where the constructions of “risky” behaviour are framed as being objective and thus morally neutral, they necessarily work to define the parameters of morality and blameworthiness.

Several writers have demonstrated that risk has become a central concept “around which health in Western society is described, organized, and practised, both personally and professionally.”³⁶ In the clinical context, risk is determined based on the characteristics of individuals, while in the epidemiological context, it is determined by observing patterns of disease in popula-

³² Weir (2006), *supra* note 7 at 14.

³³ Richard V Ericson & Aaron Doyle, “Risk and Morality” in Ericson & Doyle, *supra* note 30, 1 at 4.

³⁴ See Mary Douglas, *Risk and Blame: Essays in Cultural Theory* (New York: Routledge, 1992) at 11.

³⁵ Steve Rayner, “Cultural Theory and Risk Analysis” in Sheldon Krinsky & Dominic Golding, eds, *Social Theories of Risk* (Westport, Conn: Praeger, 1992) 83 at 87 (summarizing Douglas’ approach).

³⁶ Ann Robertson, “Embodying Risk, Embodying Political Rationality: Women’s Accounts of Risks for Breast Cancer” (2000) 2 *Health, Risk & Society* 219 at 229. See also Deborah Lupton, “Risk as Moral Danger: the Social and Political Functions of Risk Discourse in Public Health” (1993) 23 *Int’l J Health Serv* 425 [Lupton (1993)]; Alan Petersen, “Public Health, the New Genetics and Subjectivity” in Alan Petersen et al, eds, *Poststructuralism, Citizenship and Social Policy* (London: Routledge, 1999) 114.

tions, and by identifying associated risk factors.³⁷ However, as Lupton notes, both approaches render risks as “calculable and governable, thus bringing them into being as problems that require action.”³⁸

Through these techniques, pregnant women are being advised about, trained in, and made responsible for the management of risks.³⁹ They are assigned to “risk categories,” rather than treated as unique cases. Indeed, risk techniques were attached to pregnancy and childbirth as early as the 1950s with the intent of reducing perinatal mortality and morbidity: “whatever arguments are made about apparent moral neutrality, the value implications here are frequently near the surface, as with the moral (and sometimes legal) governance of those pregnant women deemed to expose their fetuses to risks.”⁴⁰ In fact, Deborah Lupton counsels us to pay attention to the political purposes to which risk discourse is put. The normative message is that it is the responsibility of the individual to avoid health risks, not just for our own safety, but for that of society.⁴¹

A consequence of this technique of governance is that the focus is placed on judging women’s behaviours rather than their intentions or motivations.⁴² “Ironically, while government can appear morally neutral in this process, the individual’s failure to govern risks becomes morally reprehensible or irrational.”⁴³ An outcome or event that may once have been viewed as “bad luck”—based on chance alone—is transformed into an event that is predictable and thus governable.⁴⁴ The modern use of risk has, as Lupton explains, a “‘forensic’ property”; it “works backwards in explaining ill-fortune, as well as

³⁷ See Deborah Lupton, “Risk and the Ontology of Pregnant Embodiment” in Lupton, *Risk and Sociocultural Theory*, *supra* note 14, 59 at 63 [Lupton (1999)].

³⁸ *Ibid.*

³⁹ See generally Weir (2006), *supra* note 7.

⁴⁰ O’Malley, *supra* note 11 at 295.

⁴¹ Lupton (1993), *supra* note 36 at 429.

⁴² O’Malley, *supra* note 11 at 293.

⁴³ *Ibid* at 295.

⁴⁴ Samerski, *supra* note 5.

forwards in predicting future retribution.”⁴⁵ The fact of harm to the fetus—the absence of the “normal, healthy” state—is given as evidence that the expectant mother failed to comply with the relevant directives to reduce risk, and therefore can comfortably be assigned blame.⁴⁶ The question of how these risks become individualized and successfully transferred to the expectant mother is taken up in the next section.

III. GOVERNING PREGNANCY

How do risky behaviours in pregnancy translate into the assignment of blame and responsibility to mothers? We argue that this occurs by both informal and formal means. Lealle Ruhl has examined how the process of risk-responsibilization works in pregnancy to create risk-conscious women.⁴⁷ As she demonstrates, risk techniques have been instrumental in shifting focus from the woman to the fetus, and in placing responsibility on the woman to become knowledgeable and competent to manage the risks to her future baby. The pregnant woman is now expected to actively engage in various gendered practices of risk detection and regulation.

A. SLIPPAGE AND EASY TRANSLATION: MEDICAL AND POPULAR DISCOURSES

Risk discourses, both medical and popular, fuel an insidious encroachment into pregnant women’s lives through the informal governance of their “lifestyle” choices, health behaviours, and decisions about prenatal care. Nowhere in medicine, claims Samerski, has risk-thinking been so powerful (and so seemingly effective) as in prenatal care.⁴⁸ This is certainly a phenomenon mediated by class considerations, as working-class women are less able to conform or to appear to conform to the high standards of behaviour ex-

⁴⁵ Lupton (1993), *supra* note 36 at 430, citing Mary Douglas, “Risk as a Forensic Resource” (1990) 119:4 *Daedalus* 1.

⁴⁶ Lupton (1993), *supra* note 36 at 430.

⁴⁷ See Lealle Ruhl, “Liberal Governance and Prenatal Care: Risk and Regulation in Pregnancy” (1999) 28 *Economy & Society* 95.

⁴⁸ Samerski, *supra* note 5.

pected of a potential mother.⁴⁹ For example, women who smoke or drink alcohol during pregnancy are subject to intense public scrutiny, as they are constantly judged by family, friends, and strangers, in a transformation of pregnant bodies into objects of public concern. This pervasive surveillance places the woman in a panopticon of observation and regulation of her choices, leading to situations in which she may begin to self-regulate in response to these perceived pressures.

Constructions of "risk" surrounding and constituting pregnancy discourses are instrumental to the self-governance and self-discipline of the pregnant body by the informal techniques of governance acting on women's bodies. The fetus is often represented as a vulnerable entity whose future existence, health, and well-being lie in the hands of the pregnant woman. However, in what is effectively a contradiction of this sole responsibility, pregnant women are also expected to entrust their bodies to the expertise of the medical community to regulate the fetus in a "responsible" transfer of control to experts.⁵⁰ Throughout their pregnancy and labour women are encouraged, even expected, to seek the expertise of health-care experts who evaluate, monitor, and regulate the fetus through a range of techniques including ultra-sound, genetic screening and testing, amniocentesis, and fetal

⁴⁹ Jana Sawicki, "Disciplining Mothers: Feminism and the New Reproductive Technologies" in Janet Price & Margrit Shildrik, eds, *Feminist Theory and the Body: A Reader* (Edinburgh: Edinburgh University Press, 1999) 190.

⁵⁰ See Lupton (1999), *supra* note 37 at 68. It should be noted that the experience of women in the care of an obstetrician might be very different from the experience of women under the care of a midwife. Midwifery often takes a very different approach to risk than does obstetrical care, and, in fact, many women report that they seek a midwife in an explicit attempt to distance themselves from many of the risk practices described here. See e.g. Brenda Lane, "Midwife or Obstetrician: How to choose between a midwife and an obstetrician for your birth" (4 January 2007), online: Suite 101 <<http://www.suite101.com>>; Charlotte Grayson, "Choosing a Pregnancy Practitioner" (21 January 2002), online: MedicineNet <<http://www.medicinenet.com>>. There is also an indication that some midwives who work with vulnerable populations (e.g. drug and alcohol users and smokers) do not automatically counsel women to stop use during pregnancy. See Diane Phillips et al, "Factors that Influence Women's Disclosures of Substance Abuse During Pregnancy: A Qualitative Study of Ten Midwives and Ten Pregnant Women" (2007) 37 *Journal of Drug Issues* 357 at 364. We are grateful to an anonymous reviewer for these insights.

monitoring.⁵¹

While we seek to expose and investigate the selection and construction of “risks” and the interests that such discourses of risk serve, this is not to deny that “real” risks may exist in pregnancy, some of which may be associated with some maternal behaviours.⁵² It is the taken-for-grantedness of risky pregnancy constructions that must be interrogated; the invisibility of “pregnancy risk” as a discourse indicates how thoroughly embedded and pervasive it is in our culture and within our informal regulatory institutions.

The “pregnancy risk” discourse thus governs the range of options available for women in terms of their behaviour in pregnancy, and carries with it evaluative judgment and blame when the technical and purportedly “amoral” rules for a safe pregnancy are not followed. O’Malley suggests that contemporary risk techniques are part of a movement towards a model of regulation that is “categorical and predictive.”⁵³ Thus, risk governance focuses mainly on behaviours and general “harm reduction” using statistics rather than direct moral persuasion. Ours is the generation of “statistically graded pregnant women”, according to Rapp.⁵⁴

A prominent example of this type of statistically-graded risk categorization comes from medical practice in relation to offering screening to pregnant women for Down syndrome and other common fetal anomalies. Because currently available screening methods are non-invasive to the fetus and minimally invasive to the mother, it has become standard practice in Canada to offer such prenatal screening to all pregnant women.⁵⁵ Amniocentesis,

⁵¹ Differences in practice can exist depending upon whether care is provided by an obstetrician or midwife, with women under the care of midwives often choosing to undergo fewer, different or no prenatal screens or tests. See Suzanne Hope Suarez, “Midwifery is not the Practice of Medicine” (1993) 5 *Yale JL & Feminism* 315 at 338.

⁵² Ernest L Abel & Michael Kruger, “Physician Attitudes Concerning Legal Coercion of Pregnant Alcohol and Drug Abusers” (2002) 186 *Am J Obstetrics & Gynecology* 768.

⁵³ O’Malley, *supra* note 11 at 294.

⁵⁴ Rayna Rapp, “Risky Business: Genetic Counseling in a Shifting World” in Jane Schneider & Rayna Rapp, eds, *Articulating Hidden Histories: Exploring the Influence of Eric R Wolf* (Berkeley: University of California Press, 1995) 175 at 180.

⁵⁵ Anne M Summers et al, “Prenatal Screening for Fetal Aneuploidy” (2007) 187 *Journal of Obstetrics & Gynecology Canada* 146.

which involves a slight risk of pregnancy loss, would only be used to reliably confirm a positive indication from initial non-invasive screening, *or* as a form of initial screening if the woman's age at the time of becoming pregnant was forty years or more, at which age the risk of giving birth to a child with Down syndrome is higher than the risk of losing a pregnancy as a result of amniocentesis.⁵⁶

Generally, the separation of governance rationales from an overt moral stance has been seen as responsible for the success of such strategies. However, while they frequently come across as technical and neutral, such strategies simultaneously assign moral blameworthiness to individuals for their failure to prevent risk or harm. This is evident in the risk calculus employed in determining to whom to offer particular types of prenatal screening. Implicit in basing the decision to offer screening on the likelihood of losing a pregnancy as a result of amniocentesis is the idea that it is as "bad" or harmful to give birth to a child with Down syndrome as it is to lose a pregnancy. Thus, a narrow focus on the techniques of harm reduction tends to obscure the moral aspect of this regulation, in this case by not examining the complex and often misconceived implications of giving birth to a child with a disability.⁵⁷

Popular women's magazines direct pregnant women to eat healthily;⁵⁸ be attentive to their levels of folate, calcium, and iron;⁵⁹ cut down on coffee;⁶⁰

⁵⁶ *Ibid* at 149.

⁵⁷ For a discussion of these issues as they relate to current prenatal screening practice, *cf.* Mark Pioro, Roxanne Mykitiuk & Jeff Nisker, "Wrongful Birth Litigation and Prenatal Screening" (2008) 179 *Can Med Assoc J* 1027.

⁵⁸ See e.g. "Tips for a Healthy Pregnancy" *Today's Parent, Pregnancy & Birth* 3:1 (Spring 2003) 44 ["Tips"]. See also Suzanne Schlosberg, "Tell Me What to Eat" (October/November 2007), online: FitPregnancy <<http://www.fitpregnancy.com>>.

⁵⁹ See e.g. Nancy Gottesman, "Top Pregnancy Nutrient: Folate" (June/July 2008), online: FitPregnancy <<http://www.fitpregnancy.com>>; Gloria McVeigh, "Stop a Childhood Cancer in Your Womb" *Prevention* 56:4 (April 2004) 68; Suzanne Schlosberg, "What You Eat = Your Baby's Future" (August/September 2008), online: FitPregnancy <<http://www.fitpregnancy.com>>.

⁶⁰ See e.g. Marty Munson & Gary Gutfield, "Baby and Java Don't Jibe: To Get Pregnant or Stay that Way, Try Putting the Cap on Caffeine" *Prevention* 46:5 (May 1994) 26.

quit smoking;⁶¹ and to consume absolutely no alcohol at any time (a message prominently featured in glossy brochures and posters displayed at liquor stores and licensed establishments).⁶² Experts also warn pregnant women of the dangers of mercury in fish in the same breath as extolling the benefits of the omega-3 fatty acids therein.⁶³ Other everyday, and often unavoidable, activities are described as risky and hazardous in the context of the pregnant woman. Pregnant women are generally encouraged to remain active; however, exercise is considered hazardous to the fetus under certain circumstances.⁶⁴ Experts also warn of the hazards of more benign activities such as lifting, pumping gas, painting the nursery, and even working.⁶⁵ Similar advice can be found on the Ontario provincial government's health website. There are links to sites on fetal alcohol syndrome; "active living for moms"; "treating the mother, protecting the unborn"; and a link to the March of Dimes site "during your pregnancy", where women are advised to avoid alcohol, smoking marijuana, a variety of drugs and herbs, abuse, hazardous substances,

⁶¹ See e.g. "Tips," *supra* note 58 (warning against the risks of first- and second-hand smoke).

⁶² See generally *Be Safe: Have an Alcohol-Free Pregnancy—Information for Health Care Providers*, online: Ontario Best Start <http://www.alcoholfreepregnancy.ca/eng/hlth_care.html>. See also Judith Springer Riddle, "Protect Your Daughter" *Prevention* 55:4 (April 2003) 165. These attempts to informally govern pregnant women's lifestyles are in spite of the fact that alcohol use during pregnancy is relatively common (and formally legal): The National Institute on Drug Abuse estimates that about 19 per cent of women in the US have used alcohol while pregnant. See Ernest L. Abel & Michael Kruger, "Physician Attitudes Concerning Legal Coercion of Pregnant Alcohol and Drug Abusers" (1995) 186 *Am J Obstetrics & Gynecology* 768.

⁶³ See e.g. Barbara Loecher, "Should I eat fish during my pregnancy? I've heard conflicting advice" *Prevention* 56:1 (January 2004) 99 (citing the benefits of omega-3 fatty acids for the growing fetus). See also "Good Question: Is fish still safe to eat?" *Today's Parent, Pregnancy and Birth* 4:2 (Autumn 2004) 10; Lisa Murphy, "The Healthiest Catch" *Chatelaine* 75:7 (July 2002) 85.

⁶⁴ See e.g. "Tips," *supra* note 58.

⁶⁵ See generally "Tips," *supra* note 58; "Can my environment harm my unborn baby?" *Today's Parent, Pregnancy & Birth* 3:2 (Autumn 2003) 34; Beth M. Iovinelli, "Can pumping gas during pregnancy hurt my baby?", online: BabyZone <<http://www.babyzone.com>>; "Is it safe to paint during pregnancy?", online: BabyCenter <<http://www.babycenter.ca>>.

mercury, and rodents. Some of this advice is not just impractical, but insensitive: it ignores social location by treating alcohol use as if it is not caught up in addiction, abuse as if it is not related to power and isolation, and the avoidance of hazardous substances as if pregnant women have the bargaining power in an employment relationship.

The links between formal and informal governance of pregnancy are numerous and often result in a grid of regulation in which the origin of the norm (state or informal) is difficult to discern.⁶⁶ Women who are visibly pregnant and choose to continue to engage in particular taboo behaviours such as smoking, drinking alcoholic beverages, eating fish, or even continuing to work in a stressful environment, may be surprised by the amount of public disdain directed towards them. In most pregnancies, women will not be aware of the direct forces of formal governance by state bodies acting on their choices. However, they are likely to be aware of the disciplining of their bodies through public perceptions of socially appropriate behaviour for pregnant women. In indirect ways, a community acts upon pregnant bodies through communication of expectations of "appropriate" behaviour for pregnant mothers. Women who are pregnant are closely monitored and an awareness of this surveillance along with a possible internalization of the goals of "producing" a healthy baby may mean obedience to public expectations even when free of the public or medical gaze: a pregnant woman may learn to self-surveil. Such surveillance practices, it is argued, constitute the body and in-

⁶⁶ The example of folate, or folic acid, serves to illustrate. Both direct and indirect means are employed from a public health perspective, aimed at reducing the incidence of neural tube defects. For example, direct state intervention has resulted in an increasing number of food products, such as flour, whole grain breads and pastas being fortified with folic acid. Health Canada states that, "[b]ecause of concern that public education campaigns alone would not be effective in achieving optimal periconceptional folic acid intake for the majority of women," food fortification with folic acid was implemented in December 1996. See Health Canada, "Evaluation of Food Fortification with Folic Acid for the Primary Prevention of Neural Tube Defects" (3 December 2004), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/faaf/chap3-eng.php>>. Indirect methods are also employed, with women "of child-bearing potential" repeatedly informed of their "obligations" to take folate supplements not only when pregnant, but also when contemplating pregnancy.

vite individuals to govern themselves, observing and monitoring their own behaviour through the operation of disciplinary power.⁶⁷

This type of governance, which, as Alan Hunt notes,⁶⁸ may be regarded as moral regulation, often does not originate from formal institutions of governance but instead can be a bottom-up process which may later be reflected in formal government policy and adjudication. Moral discourses are less explicit in contemporary times, functioning instead through their “proxies”: appeals to avoid technical and supposedly “objective” hazards and harms.⁶⁹ Pregnant women are evaluated against a good mother/bad mother standard by their own practices of harm reduction and risk avoidance, as these concepts are commonly understood. In this way, ordinary lifestyle choices and consumption of goods are moralized: Women eating junk-food, lifting groceries, or drinking a glass of wine, have these otherwise “normal” behaviours transformed and moralized by the discourses of risk that surround their pregnant bodies. Governance from “below” is ubiquitous. Whether through chiding from friends, relatives, and strangers for engaging in particular activities, or through community health projects for expectant mothers, the discourse creates moralized subjects (the mother) and objects (the fetus) to be acted upon with moralizing practices.

Public health projects are another means of governing bodies, with some persons’ bodies, like those of pregnant women, for example, being more susceptible to regulation and surveillance attempts.⁷⁰ According to Green et al, a “new psycho-socio-epidemiological model, based on population surveillance, ‘risk’ and healthy lifestyles” has been introduced in recent years.⁷¹ Largely on

⁶⁷ See Sarah Nettleton, “Women and the New Paradigm of Health and Medicine” (1996) 16:48 *Critical Social Policy* 33 at 47.

⁶⁸ See Alan Hunt, *Governing Morals: A Social History of Moral Regulation* (Cambridge: Cambridge University Press, 1999).

⁶⁹ See Alan Hunt, “Risk and Moralization in Everyday Life” in Ericson & Doyle, *supra* note 30, 165 at 182.

⁷⁰ See Alan R Petersen & Deborah Lupton, *The New Public Health: Health and Self in the Age of Risk* (London: Sage Publications, 1996).

⁷¹ Eileen E Green, Diane Thompson & Frances Griffiths, “Narratives of Risk: Women at Midlife, Medical ‘Experts’ and Health Technologies” (2002) 4 *Health, Risk & Society* 273 at 277.

the basis of “health promotion,” “we are being subjected to a form of social control based on ‘normalizing’ health narratives founded on self-regulation, self-monitoring and the avoidance of ‘risk,’ through developing healthy lifestyles and keeping well.”⁷² This shift in health policy is thought to have “engendered new internal forms of self-surveillance” as well.⁷³

This risk-based social control of pregnant women may extend beyond the time of pregnancy and target all women of child-bearing potential. For example, one report of the United States Centers for Disease Control and Prevention attempts to promote the health of future children by making recommendations that are primarily aimed at all women from menarche to menopause, regardless of whether they intend to become pregnant or not.⁷⁴ The recommendations, which include maintaining a healthy weight and giving up alcohol,⁷⁵ could involve a radical change in a woman’s life for the benefit of a person that may or may not be born in the future. This policy strategy makes risk avoidance strategies the guiding ethical principle, and both problematically assumes a shared standard of what a “healthy” child is, and downplays health determinants that are not based on individual behaviour, such as poverty, inadequate housing, and lack of health insurance.⁷⁶

Much of the moral regulation of pregnant women materializes through the privileging of expert knowledge. Programs are established which set out exemplary practices for pregnant women—such as eating healthily, taking vitamin supplements, and going for prenatal diagnostic tests—in a reflexive process of establishing and reinforcing discourses of maternal/fetal health and maternal responsibility for minimizing risks. While these programs ap-

⁷² *Ibid.* See also Nettleton, *supra* note 67.

⁷³ Green, Thompson & Griffiths, *supra* note 71 at 277.

⁷⁴ See CDC, Department of Health and Human Services, “Recommendations to Improve Preconception Health and Health Care—United States” *MMWR* 55:6 (21 April 2006) at 9, online: CDC <<http://www.cdc.gov/mmwr/pdf/rr/rr5506.pdf>>, cited in Isabel Karpin, “Taking Care of the ‘Health’ of Preconceived Human Embryos or Constructing Legal Harms” in Jeff Nisker et al, eds, *The ‘Healthy’ Embryo: Philosophical, Biomedical, Legal and Social Perspectives* (Cambridge: Cambridge University Press, 2010) 136 at 137.

⁷⁵ CDC, *supra* note 74 at 5, cited in Karpin, *supra* note 74 at 138.

⁷⁶ See Karpin, *ibid* at 141, 148–49.

pear at first glance to be technical and based upon care for the health of pregnant women and their unborn children, “there is no neat line distinguishing power from care.”⁷⁷ Responsibility and blame for the increased possibility of disease or damage is assigned through the technique of risk: As harm is conceptualized as calculable and preventable, the mother becomes blameworthy if she does not engage in approved risk-reduction strategies. The pregnant woman must rely upon the expertise of others to have what is condoned as a “safe” and “responsible” pregnancy: “risk is the *calculating* concept that modulates the relations between fear and harm.”⁷⁸ Health promotion based on statistical probabilities in the context of pregnancy can thus be viewed as the imposition of a moral technology. By being made aware of risks, the expectant mother is expected to provide for and discipline the future. As Robertson notes, however, “this experience does not occur in a vacuum; such experience is always situated, located—socially, politically, and historically.”⁷⁹

Since the advance of technologies for monitoring fetal development and health, such as ultrasound technologies, previously invisible and embodied processes become more public and open to inspection.⁸⁰ Foucault believed that through practices of increasing visibility, the increasingly penetrating medical gaze becomes seen as natural and necessary: “What was fundamentally invisible is suddenly offered to the brightness of the gaze, in a movement of appearance so simple, so immediate that it seems to be the natural consequence of a more highly developed experience.”⁸¹ As the physical processes of pregnancy become more visible, and the likelihood of harm more predict-

⁷⁷ Paulo Vaz & Fernando Bruno, “Types of Self-Surveillance: From Abnormality to Individuals ‘At Risk’” (2003) 1 *Surveillance & Society* 272 at 273.

⁷⁸ Ian Hacking, “Risk and Dirt” in Ericson & Doyle, *supra* note 30, 22 at 27 [emphasis in original].

⁷⁹ Robertson, *supra* note 36 at 231.

⁸⁰ Weir (1996), *supra* note 28.

⁸¹ Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Tavistock Publications, 1963) at 195.

able, there has been an accompanying responsabilization⁸² upon women for the “riskiness” of their behaviours in pregnancy.

Prenatal screening and diagnostic practices such as amniocentesis, ultrasound tests, and maternal serum screening, among others, are discursive in their re-framing of pregnancy, and while designed to create relief and assurance of safety, also *create* anxiety.⁸³ The construction of these tests and screens as necessary reconfigures the experience of pregnancy: “[i]n late modernity *not* to engage in risk avoidance constitutes a failure to take care of the self”⁸⁴ and possible future selves.⁸⁵ Thus risk rationalities not only *responsibilize*, or create compliant, self-regulating pregnant women, but in the process and by default, they also define and “call into being” “risky” pregnancies.⁸⁶

The impulse to warn pregnant mothers about “risky” behaviours is based on an “assumption that knowledge and awareness of the danger of certain activities will result in avoidance of these activities.”⁸⁷ But this view tends not to account for the influence of “sociocultural contexts within which risk perception takes place.”⁸⁸ For example, when risk is believed to be imposed on a fetus because of the lack of willpower, addiction, carelessness, weakness, or laziness of the expectant mother, the moral blameworthiness of her act is increased.⁸⁹ As Lupton states:

Ironically, there has been an increasing emphasis upon apprising individuals of their own responsibility for engaging in risky [behaviours] at the same

⁸² See Hunt, *supra* note 69.

⁸³ See generally Barbara Katz Rothman, *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood* (New York: Viking, 1986).

⁸⁴ Hunt, *supra* note 69 at 182. See also Lupton, *Risk*, *supra* note 14.

⁸⁵ See Mykitiuk, *supra* note 14.

⁸⁶ Laurie Adkins, “Risk, Sexuality and Economy” (2002) 53 *British Journal of Sociology* 19 at 34. See also Weir (2006), *supra* note 7.

⁸⁷ Lupton (1993), *supra* note 36 at 426.

⁸⁸ *Ibid* at 427.

⁸⁹ *Ibid* at 429.

time as the control of individuals over the risks in their working and living environments has diminished.⁹⁰

Focus on the individual lifestyle habits of a pregnant woman rather than on other factors, such as the known social determinants of health—a steady income, adequate housing, and social supports—is thought to reflect the general trend towards private responsibility for health. There is a shift from communal notions of health to an individualized or private locus of the problem: the woman's body and behaviour.⁹¹ This is characteristic of the project of neo-liberalism and its goals of enterprise and self-care. An "at-risk" consciousness "contributes to the emergence of a particular form of subjectivity—that is a particular way of thinking about, relating to and situating the self in terms of the broader social and political context within which the self is embedded/located."⁹² In fact, the particular subjectivity activated by current discourses on health and risk has been characterized as the "entrepreneurial subject,"⁹³ capturing the notion, as Robertson argues, that life is an enterprise.⁹⁴ This consciousness thus demands that individuals, including expectant women, adopt a "calculative and prudent attitude with respect to risk and danger."⁹⁵ Likewise, Nikolas Rose suggests that under neo-liberal regimes of health, "individuals are to become . . . entrepreneurs of themselves, shaping their own lives through the choices they make."⁹⁶ Fault and blame, as we will demonstrate, are cast onto the woman, as the responsibility for the health of

⁹⁰ *Ibid* at 429.

⁹¹ See Mykitiuk, *supra* note 14.

⁹² Robertson, *supra* note 36 at 230.

⁹³ Nikolas Rose, *Governing the Soul: The Shaping of the Private Soul* (London: Routledge, 1990) [Rose (1990)]; Nikolas Rose, "Government, Authority and Expertise in Advanced Liberalism" (1993) 22 *Economy & Society* 283 [Rose (1993)]; Petersen & Lupton, *supra* note 70.

⁹⁴ Robertson, *supra* note 36 at 230. See also Petersen & Lupton, *supra* note 70.

⁹⁵ Alan R Petersen, "Risk and the Regulated Self: The Discourse of Health Promotion as Politics of Uncertainty" (1996) 32:1 *Journal of Sociology* 44 at 51, citing Rose (1993), *supra* note 93 at 296.

⁹⁶ Rose (1990), *supra* note 93 at 226.

her future child becomes privatized. The “duty to be well” that is implied by public health discourses, and the call on individuals to take up and act on risk information, are the conduits of the moral element.⁹⁷ In other words, when risks are known, blame easily follows.⁹⁸

The informal translation of risk to blame is situated within the larger changing discourse of health at both a national and global level, reflecting neo-liberal agendas. Women with children harmed in utero may be blamed, as the injury can be conceptualized as the “fault” of the mother based on her own personal choices and her individual failure to protect the fetus. This move transforms health from a social good into a private commodity.⁹⁹ However, it is also possible to look at the benefit-conferring properties of risk techniques, particularly those that employ insurance as the risk-pooling mechanism, as we will in Part V, and it is true that some benefits may be distributed through these techniques. Still, these trends towards an individualization and privatization of health reflect global economic trends towards a neo-liberal and risk-based society in which increasing focus is placed upon internal regulation and surveillance.

On the other hand, as Weir and Ruhl have made clear,¹⁰⁰ efforts to enlist women in the governance of their own pregnancies cannot be said to derive solely from neo-liberal ideas about active citizenship, nor do they represent an “autonomous change in medical thought and practice”.¹⁰¹ These efforts must, in part, be attributed to feminist resistance to subordination by “experts”: to demands that pregnant women be informed and empowered to not only participate in, but to be in control of, to be made “agents” of, their own experiences with pregnancy and childbirth (as demonstrated by the increase in use of midwife-assisted births). And interestingly, it is concerns about women’s autonomy, forwarded by feminists, that has led to the resistance in

⁹⁷ Monica Greco, “Psychosomatic Subjects and the ‘Duty to Be Well’” (1993) 22 *Economy & Society* 357. See also Polzer & Robertson, *supra* note 11.

⁹⁸ Hannah-Moffat & O’Malley, *supra* note 10.

⁹⁹ See Mykitiuk, *supra* note 14 at 313.

¹⁰⁰ See Weir (1996), *supra* note 28; Ruhl, *supra* note 47.

¹⁰¹ Hannah-Moffat & O’Malley, *supra* note 10 at 10.

the courts to the same translation between risk and blame that is so easily made in the context of medical and popular discourses. In the next section, we detail the trajectory of the Canadian jurisprudence on liability for prenatal injuries to demonstrate how and in what contexts this has happened.

B. RESISTANCE TO TRANSLATION: FORMAL STATE MECHANISMS

In contrast to medical and popular discourses that effectively regulate pregnant women's behaviour through the translation of risk to blame, the judiciary in Canada, in recent years, has been an ardent protector of women's bodily autonomy throughout pregnancy, even when women have not governed themselves in expected ways. The judicial branch, in particular, can be seen as a longstanding source of resistance to the spread of risk-based models in legal decision-making, even in political contexts that regularly employ techniques of risk in informal governance in creating attributions of fault and blame.¹⁰² Though at least one dated Canadian case sought to protect a fetus from the risk of harm by the pregnant woman,¹⁰³ in general, Canadian courts at all levels have steadfastly refused to make or enforce the link between risk and blame.

This reluctance to hold a pregnant woman liable for a risk of harm to her fetus can be seen in a number of controversial cases.¹⁰⁴ It is necessary here to distinguish cases where harm to a born alive child has occurred in utero, from cases where there is a risk that such harm may occur to an unborn child. Central to the approach taken by the courts is the fact that in Canadian law, a fetus is not a legal person and does not have a legal identity separate from

¹⁰² O'Malley, *supra* note 11 at 304.

¹⁰³ See *Re Children's Aid Society of Bellville, Hastings County and T et al* (1987), 59 OR (2d) 204, 7 RFL (3d) 191 (Prov Ct (Fam Div)), in which an unborn child was allowed to be apprehended as a ward of the state.

¹⁰⁴ See e.g. *Re A (in utero)* (1990), 75 OR (2d) 82, 72 DLR (4th) 722 (Unified Fam Ct); *NH v Children's Aid Society of Regional Municipality of Waterloo*, [1996] OJ No 4788 (Ct J (Prov Div)) (QL). The courts will, however, find liability where the legislation specifically provides for it. See e.g. *Dobson (Litigation Guardian of) v Dobson*, [1999] 2 SCR 753, 174 DLR (4th) 1 [*Dobson* cited to SCR].

that of the woman carrying it.¹⁰⁵ For example, in *Re Baby R*,¹⁰⁶ the British Columbia Supreme Court held that the Family and Child Services Department could not apprehend a child prior to birth, as an unborn child did not meet the definition of “a child in need of protection” as required by the legislation. The court determined that the power to order apprehension of an unborn child would have serious consequences for the rights and autonomy of women. On the other hand, once a child has been born alive, courts have looked to events that occurred while the child was in utero in making a finding that the child is “in need of protection.”¹⁰⁷

Similar to *Re Baby R*, in *Winnipeg Child and Family Services (Northwest Area) v DFG*,¹⁰⁸ the Supreme Court of Canada refused to grant a tort remedy, which would have amounted to an injunction in the form of physical detainment and forced treatment, against a pregnant Aboriginal woman who was addicted to glue sniffing. The majority of the court took the social circumstances of the pregnant woman into account, noting that she was doing her best in a situation of “inadequate facilities and the ravages of addiction.”¹⁰⁹ The court also cited a number of policy arguments that mitigated against the imposition of liability, such as the fact that current medical research would become relevant to a court’s determination of risk; women in lower socio-economic groups would be more negatively impacted; women may come into conflict with friends and loved ones seeking to monitor and police her behaviour; and finally, the court was also concerned that the im-

¹⁰⁵ See *Winnipeg Child and Family Services (Northwest Area) v DFG*, [1997] 3 SCR 925, 152 DLR (4th) 193 [*DFG* cited to SCR]; *Tremblay v Daigle*, [1989] 2 SCR 530, 62 DLR (4th) 634.

¹⁰⁶ (1988), 53 DLR (4th) 69, 30 BCLR (2d) 237 (SC). See discussion in Weir (2006), *supra* note 7 at 158–60.

¹⁰⁷ See e.g. *Re Children’s Aid Society for the District of Kenora and JL* (1981), 134 DLR (3d) 249 (Ont Prov Ct (Fam Div)); *British Columbia (Superintendent of Family and Child Services) v McDonald* (1982), 135 DLR (3d) 330, 28 RFL (2d) 278 (BCSC). See discussion in Weir (2006), *supra* note 7 at 154–56.

¹⁰⁸ *DFG*, *supra* note 105.

¹⁰⁹ *Ibid* at para 5.

sition of liability could endanger women and babies by causing pregnant women to avoid seeking medical treatment.

The state of the law in Canada following *DFG* is that a tort action cannot succeed against a pregnant woman on behalf of her fetus. In *Dobson (Litigation Guardian of) v Dobson*,¹¹⁰ however, the Supreme Court of Canada faced a slightly different question: Should a child, once born, have the right to sue his mother for harms alleged to have occurred due to the mother's negligent behaviour during pregnancy? The majority of the Court (consisting of a majority judgment and a concurring judgment endorsing the same result, but emphasizing different reasons), answered in the negative, refusing to find a mother liable for negligent driving that caused serious injury to her fetus. This was notwithstanding that the child would be able to recover in these circumstances had anyone but the mother been at fault. The majority judgment identified two main reasons why a pregnant woman should not owe a duty of care to her fetus: first, it would entail severe implications for the privacy and autonomy rights of women; and second, it would be difficult to articulate a sound standard for responsible conduct by pregnant women. A "reasonable pregnant woman" standard, it was held, would lead to too much scrutiny of pregnant women's lives and would unfairly prejudice women who are poor, racialized, or abused. The concurring judgment emphasized *Charter* values, in particular that the liberty and equality rights of women would be violated by a finding of liability in these circumstances. Both the majority and concurring judgments were concerned with the implications of liability for pregnant women's lives in many other circumstances. They also both stated that the common law was incapable of carving out a narrow, categorical exception to the absence of duty of a mother to her child for injuries sustained while in utero (the proposed exception of course covering situations involving negligent driving to the extent that third party insurance would cover the damages). However, both the majority and concurring judgments asserted that provincial legislatures could create such a regime through legislation.

¹¹⁰ *Supra* note 104.

The dissenting judgment held that a mother should be liable for injuries to her born alive child where those injuries resulted from the negligent actions of the woman when the child was a fetus. The duty of care would only apply, however, where a woman already owes a duty of care to other third parties (such as when operating a motor vehicle). This precise issue was revisited again in *Hall (Litigation Guardian of) v Kellar*,¹¹¹ in which the infant, by its litigation guardian, brought a claim against his mother for injuries sustained in a motor vehicle accident while “*en ventre sa mere*.” It was alleged that the child’s injuries were a direct result of the accident, caused by the mother’s negligence. She was eight months pregnant at the time. The Ontario Superior Court of Justice followed the majority in *Dobson*, holding that a legal duty of care cannot and should not be imposed upon a pregnant woman towards her fetus, but, as in the *Dobson* case, leaves open the possibility that legislation could carve out a narrow exception to this general rule.¹¹²

Rosamund Scott emphasizes the role played in shaping the judgments in *Dobson* of “legal method” (or developing the law through jurisprudence versus legislation).¹¹³ She reviews the majority’s attempts to describe driving as legally indistinguishable from other forms of parenting or lifestyle choices a pregnant woman may make, such as those concerning diet or “rollerblading, shopping in a crowded mall, spraying weedkiller on her crops, sailing, lighting fireworks for her children on Canada day, or any other activity where there is a risk of harm to the general public.”¹¹⁴ Citing American and Austra-

¹¹¹ (2002), 23 CCLT (3d) 40 (Ont Sup Ct J).

¹¹² In *Paxton v Ramji*, 2008 ONCA 697, 92 OR (3d) 401, a case involving the prescription of a teratogenic drug to a 25 year old woman and the obligations of a physician to his patient’s possible future child, the Ontario Court of Appeal held that the physician did not owe a duty of care to the future child of the female patient. Recognizing a duty of care to the future child would result in conflicting duties on the physician, whose responsibility is to his female patient. For a discussion of the issue of conflicting duties owed to children and families in the child protection context, see also *Syl Apps Secure Treatment Centre v BD*, 2007 SCC 38, [2007] 3 SCR 83.

¹¹³ See Rosamund Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict* (Oxford: Hart Publishing, 2002) [Scott (2002)].

¹¹⁴ *Dobson*, *supra* note 104 at para 60, quoting Ian Kerr, “Pre-Natal Fictions and Post-Partum Actions” (1997) 20 Dal LJ 237 at 270–71.

lian case law, she argues that the distinction is possible, and explains that the majority in *Dobson* was unwilling to engage in shaping the common law in an area involving “highly sensitive public policy and insurance issues”.¹¹⁵ Regarding insurance, Scott finds a contradiction between the majority’s public policy finding that a duty would threaten the interests of pregnant women, and the fact that accessing insurance funds would have been in the interest of both the child and the mother in this case.¹¹⁶ This accordingly is another reason the court suggested the legislature tackle the issue. Scott concludes her discussion of motor vehicle insurance and maternal-fetal duty by observing that because third party injury motor vehicle insurance is mandatory and widespread, it begins to look like a first-party insurance regime. She considers replacing the costly tort system with a formal system of first-party insurance, though she notes that this position has been held as impractical.¹¹⁷ In Part V we consider in detail how insurance relates to maternal tort liability and the imposition of blame in pregnancy.

The courts’ reluctance to make an easy translation from risk to blame cannot only be seen in limits to rights relating to fetuses and injuries sustained while in utero, but also in the judicial treatment of “risks.” Courts, in general, will not take judicial notice of risky behaviour or situations, preferring to rely on the evidence of those who have specific knowledge of the pregnant woman’s actions or medical situation, or who are experts in the field of fetal risks. For example, in *AJ v Yukon Territory (Family and Children Services, Director)*,¹¹⁸ the Supreme Court of Yukon held that a law allowing a woman to be required to participate in supervision or counselling because of a risk that her unborn child could be affected by Fetal Alcohol Syndrome would unjustifiably infringe the woman’s *Charter* rights. In particular, the court found that the trial judge erred in taking judicial notice of the meaning of Fetal Alcohol Syndrome (which was mentioned in the statute but not defined). Although long accepted that alcohol can harm the fetus, the court

¹¹⁵ Scott (2002), *supra* note 113 at 328.

¹¹⁶ *Ibid* at 331–32.

¹¹⁷ *Ibid* at 339–40.

¹¹⁸ [1986] YJ No 40 (SC) (QL).

held that a precise definition of the syndrome must be established before it could be decided if the fetus was at serious risk of suffering from it.

In *Re A (in utero)*,¹¹⁹ the Ontario Unified Family Court accepted evidence from a psychiatrist that the father fit within the diagnosis of Antisocial Personality Disorder, and from a psychologist that he was prone to temper outbursts and threats of violence. The court also accepted evidence that the mother had lied to authorities about her prenatal care, and expert evidence from a pediatrician about the need for highly supervised care in this case due to risks to both mother and child. In the end, however, the court did not order apprehension because the legislation did not extend protection to unborn children.

In *New Brunswick (Minister of Health and Community Services) v NH (Litigation guardian of)*,¹²⁰ the mother admitted to consuming drugs and alcohol in two prior pregnancies, but there was no evidence of substance abuse in this pregnancy. In the result, the New Brunswick Court of Queen's Bench held that a legislative provision which gave the Minister of Health and Community Services power to grant a Supervisory Order over unborn children was an unjustified infringement of the *Charter*. In part, the court was concerned that the legislation set out no parameters for intervention with respect to unborn children. For example, the court wondered whether the Minister could take into account the woman's past conduct, and how the Minister would judge her present conduct (for example, if a woman smoked, overate, was sedentary or was overactive). The court was also concerned that the legislation did not differentiate between the developing stages of the fetus. Could the Minister intervene at any time or only when the fetus is viable? Ultimately, the court was not satisfied with the statute's imprecise terms, suggesting that there must be some clarity in the statute about the meaning of "risk to a fetus". Further, recall that in *DFG* the court noted that a determination of risky behaviour must occur in a social context: there, one in which a pregnant Aboriginal woman was addicted to glue sniffing. The court held that the risk to the fetus must be considered in the context of the

¹¹⁹ *Supra* note 104.

¹²⁰ (1996), 224 NBR (2d) 80 (QB (Fam Div)) [*NH*].

mother's personal struggle with addiction and inadequate social resources. The court also noted that using medical research and expertise to evaluate risk would be dangerous and would disproportionately affect certain groups of women.¹²¹

As Valverde et al demonstrated in 2005, contemporary risk-based governance "[does] not necessarily involve parachuting scientific or technical experts to make determinations of risk in legal contexts."¹²² With respect to judicial hearings on whether community notification should occur upon the release of a sex offender, for example, Valverde et al found that consideration of the risks of recidivism often feature legally-trained personnel such as prosecutors or judges assuming the task of measuring or assessing risks on the basis of "common knowledge," or, at least, a hybrid mix of expert and everyday knowledge. But with respect to the "risks" inherent in pregnancy, courts have not adopted the risk assessments embedded in the popular and medical discourses as "common sense." Here again we see the law in the area of maternal tort liability, with few exceptions, as a site of resistance. While it is clear that the informal regulation of pregnant women invariably involves actors drawing on a "common fund"¹²³ of knowledge, expert and everyday, to draw conclusions about "risky behaviours" and to pass judgment on pregnant bodies, the formal avenues of state law have steered clear of this.

In this way, one can view the jurisprudence reviewed above as maintaining separation between legal and health/medical knowledge.¹²⁴ While the former maintains the legal fiction of birth as the commencement of personhood in order to protect the rights of women, the latter employs risk analysis to arrive at "[e]stimates of the probability of negative health outcomes from exposures", and implies that women be held accountable for these.¹²⁵ In turn, government bodies such as child welfare agencies, from the perspective of Foucauldian population power, attempt to "prevent perinatal risk even in the

¹²¹ DFG, *supra* note 105 at paras 38–43.

¹²² Valverde, Levi & Moore, *supra* note 26 at 116.

¹²³ *Ibid* at 115.

¹²⁴ See Weir (2006), *supra* note 7 at 164, 173.

¹²⁵ *Ibid* at 172.

absence of individual harm in order to reduce the population of children who were its permanent wards.”¹²⁶ In contrast, focusing on individual rights and equity, courts have recognized that because the physical location of the fetus is inside the woman’s body,¹²⁷ and because as a consequence a woman can never be alone but may anytime affect the fetus through her actions, the protection of the bodily integrity of women requires that they not be treated as third party tort defendants whose lives are not constantly affected by the existence of the fetus.¹²⁸ In addition, it is not just any pregnant women who are subject to informal risk-based regulation, but those in lower socioeconomic groups.¹²⁹ Almost all of the women involved in the cases discussed here are Aboriginal.¹³⁰

In contrast with the efforts of branches of government such as child welfare agencies, as outlined in the cases above, other bodies of formal governance in Canada, such as the legislature and the judiciary, have been stalwart protectors of women’s autonomy over their own bodies throughout pregnancy. Until the recent extension of liability for fetal harm to mothers in cases of negligence in automobile accidents in Alberta, to be explored in the next section, pregnant women have been formally treated in law as not culpable for harm to their fetuses, even when other parties may be held responsible for such resulting harms. These high standards of protection for women have not been reflected in myriad other informal means of regulation of pregnant women’s behaviour: instead, the dominant discourse is one in which the behaviours of potential mothers, and in particular—their risk governance choices—are seen as directly and almost solely determinant of the health of the unborn.

¹²⁶ *Ibid* at 168.

¹²⁷ See the discussion of the case law in Scott (2002), *supra* note 113 at 312.

¹²⁸ *Ibid* at 335; *Dobson*, *supra* note 104 at paras 27–28.

¹²⁹ *DFG*, *supra* note 105 at para 40.

¹³⁰ See the discussion in Weir (2006), *supra* note 7 at 179–80.

IV. TRANSLATING RISK TO BLAME

Canadian law has traditionally and steadfastly refused to assign legal blame and responsibility to mothers for harms to the fetus before birth, even in situations of her negligence. A fairly recent legislative change in Alberta, however, may indicate a reversal of this trend. The *Maternal Tort Liability Act*¹³¹ came into force on 1 December 2005. It amends the law of maternal liability for harm to a fetus by permitting a child, once born, to sue its mother in cases of automobile accidents in which the pregnant mother was at fault and her fetus was injured.¹³² Importantly, the Act restricts liability to the extent of the motor vehicle insurance coverage.¹³³ The current state of the common law, as the previous section detailed, allows the injured child, once born, to sue anyone *except* the mother, the rationale for this being that if the child is able to sue the mother for damages inflicted upon it while in the womb, this may open the door for claims against mothers for 'risky' lifestyle choices during pregnancy, leading to restrictions on her autonomy. The legislative change was prompted by the case of *Rewega*.¹³⁴ In that case the pregnant woman was operating a vehicle when she lost control, causing it to roll. She was five months pregnant at the time. Her child was born prematurely with severe cognitive and physical injuries, including blindness. Following *Dobson*, the child had no cause of action against the mother.

In this part, we examine the Alberta legislation in context and ask: What are the implications of tightening the link between risk and blame in this situation? A weakness of the governmentality approach is that it often reduces risk governance "to a reflex of political ideology" which is thought to

¹³¹ *MTLA*, *supra* note 9.

¹³² See *ibid.* Section 3 states that the Act establishes "a limited exception to the immunity that a mother has at common law from actions in tort by her child for injuries suffered by the child on or after birth as a result of the mother's actions prior to the child's birth".

¹³³ *Ibid.*, s 5(1).

¹³⁴ *BR v LR*, 2004 ABQB 93, 355 AR 50, aff'd *sub nom Rewega (next friend of) v Rewega*, 2005 ABCA 365, 380 AR 224 [*Rewega*]. The *MTLA* addresses the same policy area as a private bill called the *Brooklynn Hannah George Rewega Right of Civil Action Act*, first presented to the Alberta legislature in 2004.

compromise the capacity of the approach “to evaluate the benefits of different risk-based approaches.”¹³⁵ Thus, by closely parsing the intentions and the expected effects of the legislation here, where it seems to facilitate the translation between risk and blame so far resisted by formal law, we can evaluate, rather than assume, the politics of the risk governance technique. Does the tie to insurance coverage, in this case, mitigate the individualizing effect? Is risk-based governance, in this case, more effective at delivering resources to the harmed? Does the “effect of the legislation”, as Ali states, simply amount to “providing financial assistance to women who have children with special needs”?¹³⁶

A. IMPLICATIONS OF THE TRANSLATION FROM RISK TO BLAME IN THE *MTLA* IN THE CONTEXT OF CONCERNS ABOUT WOMEN’S AUTONOMY

In *Dobson*, the action was brought on the child’s behalf by his maternal grandfather, with the apparent support of the child’s mother. The action was defended by the mothers’ insurer. A finding of legal liability would have provided the child’s family with the resources required to provide him with services required as a result of his special needs. In the words of the court: “the material interests of the mother and child are aligned, notwithstanding the fact that their legal relationship is adversarial.”¹³⁷ This situation has led many commentators to conclude that the Court in this case “upheld [the mother’s] abstract rights at the expense of the very real needs of herself and her child.”¹³⁸

The *Dobson* case is controversial because it raises the tension between the potentially very dangerous consequences of imposing a general tort liability

¹³⁵ O’Malley, *supra* note 11 at 302.

¹³⁶ Kristin Ali, “Defining the Standard of Prenatal Care: An Analysis of Judicial and Legislative Responses” (2007) 1 McGill Health Law Publication 69 at 74.

¹³⁷ *Dobson*, *supra* note 104 at para 72.

¹³⁸ Diana Ginn, “A Balancing that is Beyond the Scope of the Common Law: A Discussion of the Issues Raised by *Dobson* (*Litigation Guardian of*) *v Dobson*” (2001) 27 Queen’s LJ 51 at 84.

on pregnant women with respect to their unborn children, and the desire to compensate and support injured children with special needs (and their families). The refusal to impose maternal tort liability for prenatal negligence—an “exception” carved out in tort law to protect women’s autonomy over their bodies—leaves an injured child (and his or her family) without recourse to insurance, and thus often without resources. This is obviously not a desired result. But finding a duty of care, as several courts have concluded, would lead to increased surveillance of women and in particular, of pregnant bodies. Further, commentators have argued that state surveillance of pregnancy would do little to ensure that children are born healthy.¹³⁹

In justifying the exception, for example, the Supreme Court of Canada in *Dobson* notes the “fundamental difference between a mother-to-be and a third-party defendant”:

The unique relationship between a pregnant woman and her foetus is so very different from the relationship with third parties. Everything the pregnant woman does or fails to do may have a potentially detrimental impact on her foetus. Everything the pregnant woman eats or drinks, and every physical action she takes, may affect the foetus. Indeed, the foetus is entirely dependent upon its mother-to-be. Although the imposition of tort liability on a third party for prenatal negligence advances the interests of both mother and child, it does not significantly impair the right of third parties to control their own lives. In contrast to the third-party defendant, a pregnant woman’s every waking and sleeping moment, in essence, her entire existence, is connected to the foetus she may potentially harm. If a mother were to be held liable for prenatal negligence, this could render the most mundane decision taken in the course of her daily life as a pregnant woman subject to the scrutiny of the courts.

Is she to be liable in tort for failing to regulate her diet to provide the best nutrients for the foetus? Is she to be required to abstain from smoking and all alcoholic beverages? Should she be found liable for failing to abstain from strenuous exercise or unprotected sexual activity to protect her foetus? Must she undertake frequent safety checks of her premises in order to avoid falling and causing injury to the foetus? There is no rational and principled limit to

¹³⁹ *Ibid* at 53, n 3.

the types of claims which may be brought if such a tortious duty of care were imposed upon pregnant women.¹⁴⁰

Extending maternal liability poses additional threats to the autonomy of pregnant women. This is so, first, because it is difficult if not impossible to articulate a standard of conduct for pregnant women. Such a standard would, in the words of the majority judgment in *Dobson*, “involve an analysis of the risks associated with a given activity, the gravity of the possible injury, and the likelihood of that injury occurring”.¹⁴¹ Such a standard is inappropriate as it “raises the spectre of judicial scrutiny and potential liability imposed for ‘lifestyle choices.’”¹⁴² A court could, for example, find that a woman “should not smoke cigarettes or drink alcohol.”¹⁴³ Further, “the great disparities which exist in the financial situations, education, access to health services and ethnic backgrounds of pregnant women. . . . would inevitably lead to an unfair application of a uniform legal standard concerned with the reasonable pregnant woman.”¹⁴⁴

A second way in which extending liability would threaten the autonomy of pregnant women is in the potential imposition of tort remedies, namely the payment of damages and injunctions. Because the fetus is physically located inside the body of the pregnant woman,¹⁴⁵ indeed, it is part of the body of the pregnant woman, and because the pregnant woman can never be alone,¹⁴⁶ imposing a duty in tort would mean that “each choice made by the woman in relation to her body will affect the fetus and potentially attract tort liability.”¹⁴⁷ For these same reasons, an injunction could involve the involuntary physical detention of the pregnant woman. On this issue, the ma-

¹⁴⁰ *Dobson*, *supra* note 104 at paras 27–28. See also Morgan, *supra* note 2 at 373, n 6.

¹⁴¹ *Dobson*, *supra* note 104 at para 52.

¹⁴² *Ibid* at para 53.

¹⁴³ *Ibid.*

¹⁴⁴ *Ibid* at para 54.

¹⁴⁵ See Scott (2002), *supra* note 113 at 306.

¹⁴⁶ *Ibid* at 335.

¹⁴⁷ *DFG*, *supra* note 105 at para 37.

jority in *DFG* stated that “the principles of tort law have never been used to justify the forcible detention and mandatory treatment of a person”, and that “[t]he order at issue on this appeal can be upheld only by a radical extension of civil remedies into the most sacred sphere of personal liberty—the right of every person to live and move in freedom.”¹⁴⁸

What is the effect of the *MTLA*? Is it, as Ali states, simply to provide funds to women who have children with special needs?¹⁴⁹ We argue that the legislation provides for compensation to flow to *some* women who have children with special needs, but only a narrowly circumscribed group. Whose child qualifies for compensation under the Act? A child born with special needs, as a result of a car accident in which her mother drove negligently and has car insurance, will recover. These mothers are excepted from the maternal tort immunity by the legislation. Who is still subject to the immunity? Non-negligent mothers who were drivers in an accident that injured their future child; non-negligent mothers who were not in car accidents and whose child was born with special needs; and negligent mothers who were in car accidents that injured their future child but are not insured. In all of these cases, the mother will not be excepted from the immunity and the child will not recover.

In other words, babies suffering harms that cannot be tied to negligence will not be candidates for compensation. Thus, a potential unfairness exists between children born injured due to a car accident in which their mother drove negligently while they were still in utero, and children injured in an accident not due to negligence. The needy child of the negligent mother would recover from her insurance company, and the needy child of the non-negligent mother would not.¹⁵⁰ Nor would the needy child of the uninsured mother recover, whether she drove negligently or not. And perhaps most importantly, the child born with special needs that cannot be attributed to any accident at all, perhaps to any *cause* at all, will not be compensated. If the

¹⁴⁸ *Ibid* at para 46.

¹⁴⁹ Ali, *supra* note 136.

¹⁵⁰ Unless someone other than the mother negligently caused the accident, and thus the injury.

intent of the legislation is not to burden mothers or families financially (which was articulated as the rationale for limiting liability to the extent of the mother's insurance coverage), it accomplishes this goal for only a narrow set of women. If the unfairness that the legislation aims to address is that between children born with special needs injured by negligent third parties prior to their births, and those injured by the negligent behaviour of their mothers before their births, the legislation addresses one inequity while leaving several others intact.

A further remaining unfairness arises from, as Ali acknowledges, the fact that compensation is restricted to the amount of the mother's insurance coverage, which might differ drastically between families.¹⁵¹ Two children who suffer similar injuries, in identical circumstances, may receive vastly different compensation awards, and will thus have access to different levels of support and services where they are provided on the basis of an ability to pay. This issue also emerged in the legislative debates surrounding the passage of the *MTLA*. One member remarked, "If people have different levels of insurance, you know, is this the way by which we're going to determine the care of someone who needs care as a disabled person?"¹⁵² Proponents of the Act, however, acknowledged that it was not meant to be a comprehensive solution, and asserted that it would create a narrow avenue for compensation or close a gap in the tort system in a small way. One member described the function of the Act as creating "a very narrow exception".¹⁵³

As Hannah-Moffat and O'Malley have noted, analyses of risk governance techniques rarely pay adequate attention to "gender, racial and ethnic differences, or to the social, economic and political contexts in which these tools are deployed".¹⁵⁴ In this case, those most likely to be affected by infringement on their liberty and autonomy by further surveillance and judging of pregnant women's behaviours—racialized and marginalized women, including

¹⁵¹ Ali, *supra* note 136 at 76.

¹⁵² Alberta, Legislative Assembly, *Hansard*, 26th Leg, 1st Sess (16 November 2005) at 1684 (Mr Eggen).

¹⁵³ *Ibid* (21 November 2005) at 1773 (Mr Stevens).

¹⁵⁴ Hannah-Moffat & O'Malley, *supra* note 10 at 18.

Aboriginal women as the cases demonstrate, particularly those that are street-involved or who struggle with addiction—are the least likely to benefit from the extension of liability, i.e. they are the least likely to be insured. Not only are the discourses of risk governance “structured by class,”¹⁵⁵ but the risk governance technique chosen to ameliorate the situation for women—the imposition of liability—takes class as its central organizing framework.

As Ali notes, “[a] solution that would advance the objective of providing compensation to families with children who have special needs would be the creation of a fund that would assist all families in this situation, and not just those who have automobile insurance whose children were injured from negligent driving.”¹⁵⁶ In fact, Cory J in *Dobson* suggested the creation of a fund to cover prenatal injuries:¹⁵⁷

The Act may not provide the best solution to all families with children who sustain prenatal injuries, but it does allow some children to recover some compensation that would otherwise not be available because of the ruling in *Dobson*.¹⁵⁸

A better solution, of course, would be to provide funding according to need. In a truly collective or socialized model, *services* would be provided instead of income or cash compensation to alleviate the consequences of adverse effects.¹⁵⁹ Specifically, “[i]ncreasing state funding for social support services would contribute much more to the well-being of those with special needs than a legislatively-imposed standard of pre-natal care would, and the pregnant woman’s personal autonomy would not be violated.”¹⁶⁰ While opponents in the Alberta legislature of the *MTLA* argued that the state was in effect “trying to download the duty of care to insurance companies for chil-

¹⁵⁵ Ruhl, *supra* note 47 at 96.

¹⁵⁶ Ali, *supra* note 136 at 76.

¹⁵⁷ *Dobson*, *supra* note 104 at para 48.

¹⁵⁸ Ali, *supra* note 136 at 76.

¹⁵⁹ Deborah Stone, “Beyond Moral Hazard: Insurance as Moral Opportunity” (1999) 6 Conn Ins LJ 11 at 34.

¹⁶⁰ Ali, *supra* note 136 at 80.

dren born alive with defects”;¹⁶¹ proponents countered that “[n]othing in this legislation extinguishes any other government program, infringes upon, or changes any assistance programs.”¹⁶²

A second effect of the legislation is that it essentially forces families to turn to litigation (which is inherently adversarial and confrontational) for their remedy, rather than to look to the state for support based on their genuine needs.¹⁶³ As Ali suggests and the case law illustrates, this tends to increase tension in the family unit, but it also inevitably imports notions of blame. The Act creates the possibility of finding the mother liable, *negligent*, and thus blameworthy in causing injuries to herself, as the carrier of the fetus, and the subsequently-born child. Opponents of the *MTLA* in the Alberta legislature noted a concern with a possible “new raft of lawsuits, perhaps spurious lawsuits, in regard to what might be perceived as an expansion of fetal rights here in this province.”¹⁶⁴ Those who supported the bill, however, noted that children are already able to sue for injuries sustained “prenatally against other third parties and against other family members” and that the only function of the Act would be to include the mother along with these others.¹⁶⁵ One member also asserted that “this legislation doesn’t assign any blame, determine any negligence or any liability”,¹⁶⁶ while another noted that the Act would not focus on “maternal responsibility” but on “the responsibility of a person driving a car”.¹⁶⁷ The dynamic of blaming in the context of liability and insurance is the topic of Part V.

¹⁶¹ *Hansard*, *supra* note 152 (16 November 2005) at 1686 (Mr Bonko).

¹⁶² *Ibid* (23 November 2005) at 1874 (Mr Oberle).

¹⁶³ Ali, *supra* note 136 at 80.

¹⁶⁴ *Hansard*, *supra* note 152 (16 November 2005) at 1684 (Mr Eggen).

¹⁶⁵ *Ibid* (16 November 2005) at 1682 (Mr Oberle).

¹⁶⁶ *Ibid*.

¹⁶⁷ *Ibid* (23 November 2005) at 1873 (Mr Oberle).

V. LIABILITY AND BLAME IN THE CONTEXT OF INSURANCE

As outlined in Part II, the technique of “risk governance”, as it is treated in much of the current governmentality literature, is taken to be part of a neo-liberal political project that has the effect of “individualizing” risk. In this final part, we explore the connections between liability and insurance to analyze the possibility that, in the case of the *MTLA*, the linking of risk with blame may not necessarily be an “individualizing move.” In making the connection to the mother’s insurance policy, the strategy seeks to compensate the family by drawing on the collective resources of the insurance pool. How should we evaluate the politics of an insurance strategy as a way of managing the “risk” of injury in pregnancy?

On the one hand, as Deborah Stone says, “[i]nsurance is not only an institution of repair, but also of social progress.”¹⁶⁸ Stone explains that insurance is one of the primary means utilized by communities to make life better for individual members. Insurance fosters collaboration, provides security, and offers a mechanism to reinforce a sense of community and collective well being.¹⁶⁹

On the other hand, Armstrong notes, insurance is also “the paradigmatic form of risk management” within neo-liberal regimes.¹⁷⁰ Neo-liberalism is said to be in pursuit of the “‘autonomization’ of society: it seeks to achieve the unmediated government *of* individuals *by* individuals”—and specifically by rational, responsible individuals.¹⁷¹ Thus while neo-liberalism’s first choice of governance strategies may be self-reliance; its second choice is undoubtedly private insurance. And even as “[i]nsurance becomes *the* institution of governance”, it remains governance-at-a-distance.¹⁷² Thus, instead of building

¹⁶⁸ Stone, *supra* note 159 at 15.

¹⁶⁹ *Ibid.*

¹⁷⁰ Chris Armstrong, “Equality, Risk and Responsibility: Dworkin on the Insurance Market” (2005) 34 *Economy & Society* 451 at 451.

¹⁷¹ *Ibid* at 453.

¹⁷² Richard Ericson, Dean Barry & Aaron Doyle, “The Moral Hazards of Neo-Liberalism: Lessons from the Private Insurance Industry” (2000) 29 *Economy & Society* 532 at 550.

social solidarity and community, according to some scholars, the proliferation of private insurance can have the effect of fragmenting populations into separate risk-rated communities, each with a monetary value.¹⁷³

But we must acknowledge that private insurance may also operate to spread risk amongst the community.¹⁷⁴ Even while insurance is a technology of risk management, “it is also a technology of distribution, of risk sharing.”¹⁷⁵ But the socializing of risk that happens through private insurance schemes is contained within tight boundaries, and it may serve, perversely, to ease the pressure on the state for genuine collective management and pooling of risk. It is the commodification of a form of social security that could alternatively be seen as the responsibility of the state—or the collective. Thus it is not surprising to see a contemporary government support a private insurance scheme as a way of managing risk, because it is simultaneously a way of reducing individual claims on collective resources, and it displaces state responsibility.

Also, in turning to insurance as a “collectivizing” strategy, the work of governing is displaced from political systems where legislation and policy are debated in public to administrative ones where regulations are issued in private by “insurer fiat”.¹⁷⁶ In fact, as Heimer demonstrates, the regulation of driving is now influenced much more through the risk management practices of insurance companies than it is through the actions and decisions of legislatures.¹⁷⁷ Still, as the debate around the *MTLA* illustrates, “questions about system design bring insurance back into the political realm”.¹⁷⁸ Because insurance pools the savings of the community to pay for the losses of individuals,

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid* at 534.

¹⁷⁵ Carol A Heimer, “Insurers as Moral Actors” in Ericson & Doyle, *supra* note 30, 284 at 285 [Heimer (2003)].

¹⁷⁶ *Ibid* at 285. See also Carol A Heimer, “Insuring More, Ensuring Less: The Costs and Benefits of Private Regulation through Insurance” in Baker & Simon, *supra* note 13, 116 at 119 [Heimer (2002)].

¹⁷⁷ Heimer (2003), *supra* note 175 at 301.

¹⁷⁸ *Ibid* at 285.

“whenever insurance is discussed, questions of allocating responsibility between individuals and society are barely beneath the surface”.¹⁷⁹ Thus the question of which individuals will be included or excluded from the risk pools that are produced by insurance becomes a key political question.¹⁸⁰ It is essentially about the “boundaries of risk-sharing communities”¹⁸¹ and who is eligible to participate in the decisions about where those boundaries should be drawn.

Whether we accept a communal burden for adverse events, or treat them as appropriately individual burdens, is defining of a society. The primary foundation of insurance, according to Stone, “is collective responsibility for harms that befall individuals”.¹⁸² But how this plays out differs as between public and private schemes. In private, commercial insurance schemes, a premium is charged to each policyholder to create a “fund from which those who experience losses are compensated; recipients of compensation are those who contributed to the fund or their designated beneficiaries”.¹⁸³ In public schemes, the fund is built through taxation rather than premiums, and eligible recipients may be smaller or larger than the group of contributors.¹⁸⁴

Recent trends in private insurance in the neo-liberal era are towards risk “unpooling,” towards increasing segmentation of the pool of insured. In fact, according to Heimer, those “outside the system” now have more difficulty “gaining a toehold” in an effective insurance arrangement than they might have had when public schemes represented alternatives to commercial forms of insurance.¹⁸⁵ Accordingly, Heimer concludes that private insurance schemes offer a safety net of “fine resilient mesh” for the rich, but there are much larger holes in the “loosely woven safety nets of the poor”.¹⁸⁶ And yet,

¹⁷⁹ Stone, *supra* note 159 at 16.

¹⁸⁰ Heimer (2003), *supra* note 175 at 285.

¹⁸¹ *Ibid* at 307.

¹⁸² Stone, *supra* note 159 at 16.

¹⁸³ Heimer (2003), *supra* note 175 at 289.

¹⁸⁴ *Ibid*.

¹⁸⁵ Heimer (2002), *supra* note 176 at 117.

¹⁸⁶ *Ibid* at 118.

“political demands for equality in insurance challenge the fundamental principle of actuarial fairness upon which most insurance operates”.¹⁸⁷ That principle demands the classification of people according to the degree of “risk” they pose. Insurers argue that practices such as charging differential rates or precluding certain groups are merely products of objective economic realities. While there are certain groups who may appear to be the targets of discrimination, in reality they are simply treated differently as they pose an increased risk of loss.¹⁸⁸ “Those seeking insurance expansion”, as the families of children with special needs who are not “caught in the net” of the liability exception of the *MTLA* are in the context of this example, are “making the quintessential democratic claim”, according to Stone: “they are asserting their membership in a community, their right to representation in its collective decisions, and their right to equal treatment vis-à-vis other citizens”.¹⁸⁹

Part of an unpooling strategy by the insurers in response to this legislation might include the concentrating of women of child-bearing age in to their own, now uniquely “risky” category, on the basis that they objectively pose a greater risk of loss to the company. This raises the spectre of differential rates for women of child-bearing age.¹⁹⁰ According to Ali, “[w]hile increased insurance premiums are a problem, this legislation would create the larger problem of shifting what ought to be [a] state responsibility to the insurance industry, thus undermining the principle of social responsibility for those with special needs”.¹⁹¹ Whether the responsibility is shifted onto the insurance companies, or more likely, onto “drivers” as a class, if not women drivers, it undoubtedly raises the political question of the appropriate boundaries for the risk sharing community. From this analysis, we can confirm that insurance as risk governance has both *individualizing* and *socializing* elements, and that determining its politics is complicated. Importantly

¹⁸⁷ Stone, *supra* note 159 at 43.

¹⁸⁸ *Ibid.* See also Jonathan Simon, “The Ideological Effects of Actuarial Practices” (1988) 22 Law & Soc’y Rev 771.

¹⁸⁹ Stone, *supra* note 159 at 44.

¹⁹⁰ Ali, *supra* note 136.

¹⁹¹ *Ibid* at 80.

for us, a key complicating factor is the assignment of blame that comes with liability, and which is a prerequisite for recovery under the legislation, notwithstanding the limited socializing of the risk that comes from the link to insurance.

A. THE ASSIGNMENT OF BLAME

Blame is directed at women as mothers from the moment of conception, continuing throughout pregnancy, and the life of the child.¹⁹² This is where claims that regimes of risk governance can be said to be “amoral” fall short. As Hannah-Moffat and O'Malley state, “we are intruded upon and disciplined by risk regimes meant to protect us from future harms, and if we fail to buy in, we must suffer the consequences”.¹⁹³ If harm can be predicted through risk techniques, then to fall prey to harm is to be culpable.¹⁹⁴

But the expectation that pregnant women and mothers will comply and conform to the risk regimes, whether they are delivered through formal or informal means, ignores the reality of the less than perfect circumstances in which many women are required to parent,¹⁹⁵ or to be pregnant. In fact, criticism of pregnant women and mothers and the blame levelled against them does not acknowledge the progressive difficulty of conditions wherein women are forced to be mothers.¹⁹⁶ It is meted out based on the woman's success or failure with respect to achieving the singular goal: a “healthy” baby. It follows the birth without regard for the specific circumstances in which women become and are pregnant,¹⁹⁷ without regard for social, eco-

¹⁹² Debra Jackson & Judy Mannix, “Giving Voice to the Burden of Blame: A Feminist Study of Mothers' Experiences of Mother Blaming” (2004) 10 *Int'l J Nurs Pract* 150 at 151.

¹⁹³ Hannah-Moffat & O'Malley, *supra* note 10 at 1.

¹⁹⁴ See *ibid* at 14.

¹⁹⁵ See *ibid* at 239.

¹⁹⁶ Jackson & Mannix, *supra* note 192 at 156.

¹⁹⁷ Harriette Marshall & Anne Woollett, “Fit to Reproduce? The Regulative Role of Pregnancy Texts” (2000) 10 *Feminism & Psychology* 351.

nomic, or cultural constraints. As Samerski says of the pregnant woman, “all at once she is responsible even for things that she cannot influence”.¹⁹⁸

The easy translation of risk to blame that we observed in Part III with respect to the informal means of risk governance—the popular and medical discourses—was grounded in risk’s ability to predict future harms on the basis of probabilities, and on its related promise to project blame on the individual for not buying into the risk regime, should harm materialize. In the formal regime of risk governance enacted through the *MTLA*, the mechanism for ensuring that blame falls squarely on the mother is more direct: proof of her negligence must be offered, and liability will follow. But in some respects, we might say that the legislation is not a *risk* governance strategy at all. The cause of action only comes into play once the child is born injured. Harm is already evident; the notion of risk, of what *might* have happened, is rendered irrelevant by the observation of what *did* happen.

Thus we can see that focusing on the translation between risk and blame tends to obscure the link between risk and *harm*. Harm, of course, is proven upon birth. At issue in *Dobson* was only the question of whether the cause of action exists—left unexplored was the problematic question of whether it would have been possible to prove that the prenatal negligent act *caused* the harm to the fetus. In tort law, a causal analysis is a necessary prerequisite to the assignment of responsibility.¹⁹⁹ But the construction of a causal narrative is a lot more straightforward with respect to a single catastrophic event, such as a car accident, than it is with respect to “risky behaviours” like the consumption of drugs or alcohol, an “over-active” lifestyle, or the failure to take a prenatal vitamin supplement. In these situations, often the best that will be able to be argued is that the pregnant woman’s behaviour increased the risk of the harm to the fetus, and not that it *caused* the harm. And so, allowing the

¹⁹⁸ Samerski, *supra* note 5 at 69. And perhaps this should be expected: It is easier to blame pregnant women for harms to unborn children than it is to consider the role played by the larger society and governments for policies that are not supportive of women as mothers. See Jaime Burrows, “The Parturient Woman: Can there be room for more than ‘one person with full and equal rights inside a human skin’?” (2001) 33 J Adv Nurs 689.

¹⁹⁹ See generally Ernest J Weinrib, *Tort Law: Cases and Materials*, 3d ed (Toronto: Emond Montgomery, 2009).

cause of action in a very limited circumstance, such as a car accident, and only once a child is born injured, is a much different endeavour than imposing restrictions on a woman's autonomy while she is still pregnant. Remember that risk can be forward-looking and predictive, but it is only once the feared outcome materializes—once we are faced with *harm*—that risk's capacity for retribution is engaged.

In fact, a key difference in the dynamics of the translation from risk to blame in the informal governance context versus in the litigation context exists around the question of *timing*. As Landsman makes clear, there is a difference between addressing the question of disabled infants hypothetically, within the framework of pregnancy, and addressing the question of “defective” [*sic*] children at birth, within the context of “pregnancy's aftermath”.²⁰⁰ The legislation in fact avoids the very difficult aspects of prenatal “risk,” by taking as its focus the child, once born. According to Landsman²⁰¹ an important part of the character of risk is its capacity for extending the reach of governance: while “actual harm” typically must be proven, or at least demonstrated, “risk of harm” can encompass almost anything. So, in situations where harm materializes, where a child is born with special needs, and a car accident occurred, tying the harm to the “risky” (and thus culpable) behaviour is relatively straightforward.²⁰² More troubling are the situations left untouched by the legislation; namely, those in which harm materializes—a child is born with special needs—and yet, there is no obviously “risky” act to attribute it to.

In the neo-liberal order, to justify the logic that someone be held to blame for an adverse outcome, “risk must be construed as a product of human agency and therefore controllable through attributions of responsibility and

²⁰⁰ Gail H Landsman, “Reconstructing Motherhood in the Age of ‘Perfect’ Babies: Mothers of Infants and Toddlers with Disabilities” (1998) 24 Signs 69 at 71.

²⁰¹ *Ibid* at 71.

²⁰² For a thorough discussion of the legal nature of the maternal-fetal relationship, and the preservation of the legal fiction of the child *en ventre sa mere*, and thus the birth threshold, which comparable legislation permits, see Scott (2002), *supra* note 113. For a provocative discussion of the birth threshold and the perinatal threshold in law and their implications for the maternal-fetal relationship, see Weir (2006), *supra* note 7.

processes of accountability”.²⁰³ As Ericson et al note, “within a neo-liberal regime of responsible risk taking all differences, and the inequalities that result from it, is seen as a matter of choice”.²⁰⁴ And it is acknowledged that “a core element of neo-liberalism in practice is the portrayal of inequality as choice”.²⁰⁵ In this model, the eventuality of an “unhealthy” baby is transformed from a communal responsibility into a private responsibility based on the logic that it is an outcome that resulted from personal choices and actions.

There are many reasons to doubt that the outcome of an “unhealthy,” an injured, or a special needs baby, can in any real way be attributed to the personal choices and actions of its mother in the vast majority of cases. As one of the popular pregnancy guides tells women, “only a small minority of birth abnormalities . . . can be explained by known hazards”.²⁰⁶ For this reason, the state of pregnancy itself is not an easy fit with a model of governance based on insurance: there are too many potential risk factors operating at once.²⁰⁷ Fetal health depends on a complex array of interacting variables. Further, women do not “control” their pregnancies in any real sense.²⁰⁸ Economic factors influence access to prenatal care and its accessories, and social variables, such as housing, domestic abuse, and addiction, condition women’s relative capacities to create a nurturing environment for the fetus and baby.

And still, despite the fact that little effort is made at actually assessing the degree of agency women hold—the responsibility and blame for “abnormal” or “unsuccessful” outcomes in pregnancy is located squarely with the individual woman.²⁰⁹ In fact, middle class, educated women are among those who

²⁰³ Ericson & Doyle, *supra* note 33 at 7.

²⁰⁴ Ericson, Barry & Doyle, *supra* note 172 at 533.

²⁰⁵ Armstrong, *supra* note 170 at 454. See also Ericson, Barry & Doyle, *supra* note 172.

²⁰⁶ Philip D Sloane, Salli Benedict & Melanie Mintzer, *The Complete Pregnancy Workbook: A Guide for Parents-to-be* (Toronto: Key Porter Books, 1986) at 8–9.

²⁰⁷ Ruhl, *supra* note 47.

²⁰⁸ *Ibid.*

²⁰⁹ Marshall & Woollett, *supra* note 197.

are most interested in appearing to be responsible,²¹⁰ and it is with respect to these women that the discourses most effectively produce a “desire to conform”.²¹¹ Nonetheless, all women subject to this disciplinary power inevitably gain the impression that being “responsible” during pregnancy will “guarantee” a desired outcome.²¹² In fact, the very premise of the legislation is in furtherance of this myth: “that the outcome of a pregnancy depends on the pregnant woman’s responsible decision making”.²¹³

Governance mechanisms that frame problems in terms of risk and emphasize accountability open up the door for the “possibility of blame if things go wrong”.²¹⁴ Lemke argues that it is the “recourse to ‘risks’ which makes it possible to call for autonomy and self-regulation”.²¹⁵ Early promoters of social insurance schemes, as Stone notes, understood that an individual should not be held responsible for risks that she could not mitigate against.²¹⁶ But in a neo-liberal order, children have become “the embodiment of their parents’ choices”²¹⁷ with the result that “[m]others of children with disabilities make their way within a society that devalues their children and in which their motherhood has ‘failed’ to follow the culturally appropriate trajectory”.²¹⁸

We also must remember that “insurers regulate behaviour at the same time as they spread risk”.²¹⁹ The term “moral hazard” is used to describe the effect of insurance contracts on the behaviour of policyholders. In other

²¹⁰ Ruhl, *supra* note 47 at 103.

²¹¹ *Ibid.*, citing Mariana Valverde, “‘Despotism’ and Ethical Liberal Governance” (1996) 25 *Economy & Society* 357.

²¹² Ruhl, *supra* note 47 at 105.

²¹³ Samerski, *supra* note 5 at 71.

²¹⁴ Richard Ericson & Myles Leslie, “The Architecture of Risk Management” (2008) 37 *Economy & Society* 613 at 616.

²¹⁵ Lemke, *supra* note 23 at 551.

²¹⁶ Stone, *supra* note 159 at 24.

²¹⁷ Landsman, *supra* note 200 at 77.

²¹⁸ *Ibid.*

²¹⁹ Heimer (2003), *supra* note 175 at 284.

words, it is an acknowledgement of the fact that insurance contracts alter incentives. In the context of pregnancy risks, however, the concept falters. The basic idea is that “because they no longer bear the full burden of losses, policyholders have a diminished interest in preventing losses”.²²⁰ The classic example is that those that have purchased theft or fire insurance are less vigilant in preventing theft or fire, because they have less at stake. To draw the parallel with the maternal tort liability scenario would require us to accept that women who know that they have car insurance will be less careful about injuring their fetus. This is clearly not the case, even if it is the case for car accidents in general, which is doubtful. The type of risk we are talking about in this case is very different from the prototypical insurance risk, such as theft or fire. As Baker and Simon show, the typical effect of insuring against a risk is often to completely eliminate it from the day-to-day concern of people who are exposed to it. Risks that are insured are experienced in a very different manner than those risks considered as beyond insurance.²²¹ This may be true in the case of fire or theft where lost items are replaced but it is much more complicated in the case of an injured child. The fact of the injury is never altered through compensation; it is only the experience of coping, the material realities of support in its aftermath, that is changed. And of course, parents understand that “insurance compensation covers only the *monetary* losses experienced by policyholders, and often only a portion of those”.²²² The loss itself is not compensable.

More importantly, there are the lingering effects of blame. The consequence of placing the focus on the woman to guard against “risks” is that the location of blame for any adverse outcomes with respect to the pregnancy, whether they can be conceived of as harms related to the “risks” or not, is directly on the mother. In Landsman’s 1998 study of mothers of children with disabilities, all of the women indicated that they had either “struggled to determine what they might have done wrong to bring about a disability or felt that they were being wrongfully judged by others as having done some-

²²⁰ *Ibid* at 289.

²²¹ Baker & Simon, *supra* note 13 at 12.

²²² Heimer (2003), *supra* note 175 at 293 [emphasis added].

thing improper”.²²³ Further, the women’s narratives demonstrated that reproduction is publicly represented, and often accepted, as subject to the individual control of the mother. A common theme in the stories of mothers with disabled infants was the severe unfairness of feeling as though they had done everything right, of having followed all of the experts’ advice, and still having suffered the trauma of dashed expectations.²²⁴

That blame falls almost exclusively on individual mothers is true despite the recognition that many of the “risks” associated with adverse outcomes in pregnancy are objectively beyond individual women’s control.²²⁵ After all, the model essentially amounts to women taking responsibility not only for their own actions, but for their “environments” as well.²²⁶ In this sense, the state of “perpetual anxiety” that characterizes pregnancy has much in common with the experience of living with the risks of toxic chemical pollution. As Ruhl states, “the things most feared . . . are mostly invisible until their effects are [finally] manifested”.²²⁷

What more is the mother expected to take responsibility for? As Ruhl notes, “when the health of a fetus is discovered, *prior to birth*, to be ‘compromised in some way,’ women are increasingly expected to assume responsibility for that, too”, usually with a decision to terminate the pregnancy.²²⁸ In this situation, what Duden calls the “interiorization of eugenics”, women shoulder the bulk of the guilt and the blame. Now, with the imposition of liability, we further target women and make them the locus of responsibility for the health of the child.

Further, pregnancy risks as we have conceptualized them, might differ from more conventional insurance risks, “by dint of the fact that they obey less a logic of compensation and capitalization and more an imperative of

²²³ Landsman, *supra* note 200 at 80.

²²⁴ *Ibid* at 81.

²²⁵ Marshall & Woollet, *supra* note 197.

²²⁶ Ruhl, *supra* note 47.

²²⁷ *Ibid* at 201.

²²⁸ *Ibid* at 112. See also Mykitiuk, *supra* note 14.

prevention and prevision”.²²⁹ But even the discourse of prevention and precaution perpetuates this “illusion” that by following the risk-based script it is possible for women to “seize hold of the future”.²³⁰ As Ruhl notes, one consequence of the informal means of risk governance on mothers is that it leads to “a proliferation of guilt by assuming responsibility everywhere”.²³¹ Instead of relieving mothers of guilt and responsibility, the insurance scheme potentially exacerbates this effect. It “makes the woman complicit in any birth defect [*sic*] her child may possess”,²³² regardless of her degree of control over that outcome. And furthermore, adopting the script as one’s own and behaving according to its edicts in no way assures a woman the “healthy baby” she desires.

VI. CONCLUSION: COMPLICATING THE POLITICS OF RISK GOVERNANCE

This article explores the body of the pregnant woman as the object of regulation—both formal and informal—in the context of techniques of risk governance and the assignment of blame and responsibility. The question of how risk governance affects the apportionment of responsibility and the assignment of blame is an emerging priority in the socio-legal studies of risk. Where the governmentality literature on risk tends to view the translation from risk to blame as a technique of risk governance—a mechanism for “individualizing” risk—the case of Alberta’s *Maternal Tort Liability Act* reveals that the situation can be considerably more complex. Because of the explicit link to the mother’s insurance coverage, the connection between the pregnant woman’s risky behaviour, and her “blameworthiness” (and thus legal liability), can in some respects be considered a “collectivist” response to risk. That is, it serves to share or spread the financial burden of dealing with the consequences of the risk materializing—the care of the injured child—among a “risk pool” instead of imposing it on the mother or the family of the

²²⁹ Lemke, *supra* note 23 at 552 (referring to “genetic risks”).

²³⁰ Samerski, *supra* note 5 at 56.

²³¹ Ruhl, *supra* note 47 at 106.

²³² *Ibid* at 110.

child alone. Resisting the move to impose liability on the mother, as Canadian law has done in the context of insurance, would mean maintaining the “individual” responsibility for the risk as per *Dobson*.

But liability and, consequently, blame, in this example, is determined according to the law of negligence. Tort law generally, and negligence law specifically, emerged to govern the field of accidental harms.²³³ In fact, the central doctrine of negligence, according to O’Malley, ensured that legal subjects would bear the responsibility for any harm they inflicted carelessly on others.²³⁴ “[I]n a sense, torts legislated risk awareness.”²³⁵ But tort law eventually developed into a form of “social insurance”: that is, it sought to distribute loss in a socially effective manner to those best able to bear the financial burden, not necessarily those at fault.²³⁶ It became a mechanism for the collectivizing of risk. The welfare state governed largely through these social insurance technologies.

As explored, neo-liberalism is thought to be replacing these “social” risk technologies “with complex techniques of risk management based on market models, private insurance and increased individual responsibility for risk management”.²³⁷ The private insurance industry is becoming recognized as a central social institution of risk distribution and moral regulation.²³⁸ Thus, while allowing maternal tort liability (as the Alberta legislation does) can be considered a collectivizing move (because of the tie to the mothers’ insurance plan)—it should be noted that it remains essentially “privatizing.” It is a “solution” that requires families to turn to litigation and to attempt to gain compensation from a private insurance scheme, instead of imposing a social and collective responsibility to care for children born with special needs—such as through universal, publicly-funded services. The risk is not fully collectivized, or shared by society as a whole, but is confined to a narrow risk

²³³ O’Malley, *supra* note 11 at 298.

²³⁴ *Ibid.*

²³⁵ *Ibid* at 299.

²³⁶ *Ibid.*

²³⁷ *Ibid* at 301.

²³⁸ Ericson & Doyle, *supra* note 33.

pool, which in fact, may be circumscribed further as insurance companies respond to the legislation.

The withdrawal of the state from “welfare state” initiatives of the type that would deliver universal publicly-funded services to all children born with special needs goes hand in hand with an appeal to personal responsibility and self-care, as well as the establishment of self-regulatory competencies among individual and collective subjects.²³⁹ Further, it must be stressed that litigation necessarily relies on a fault-based model. The assignment of blame to the mother comes with emotional and social consequences, notwithstanding the fact that it may be in her material best interests. As Balsamo demonstrates, the female body is constantly being evaluated, even when not pregnant. It is judged for its maternal “potential,” and “evaluated in terms of its physiological and moral status as a potential container for the embryo or fetus”.²⁴⁰ Pregnant women are judged by their peers *and by themselves*.

²³⁹ Lemke, *supra* note 23 at 555.

²⁴⁰ Anne Marie Balsamo, *Technologies of the Gendered Body* (Durham: Duke University Press, 1996) at 90.